STATE OF WASHINGTON
Department of
LICENSING

PHYSICAL EXAMINATION

(VALID FOR NOT MORE THAN THREE YEARS FROM DATE OF EXAM)

PLEASE PRINT

DRIVER'S NAME *Last*	*First*	*Middle*	(AREA CODE) TELEPHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP	DATE OF BIRTH

TO BE COMPLETED BY MEDICAL EXAMINER *(Please Print)*

Answer each question yes or no where appropriate. The medical examiner should be aware of the rigorous physical demands and mental and emotional responsibilities placed on the driver of a limousine vehicle. In the interest of public safety the medical examiner is required to certify that the driver does not have any physical, mental, or organic defect of such a nature as to affect the driver's ability to operate a limousine vehicle.

Health History: Height: _____ ft. _____ in. Weight: _____ lbs.

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Muscular disease	☐	☐	Nervous stomach
☐	☐	Psychiatric disorder	☐	☐	Rheumatic fever	☐	☐	Syphilis
☐	☐	Cardiovascular disease	☐	☐	Asthma	☐	☐	Gonorrhea
☐	☐	Head or spinal injuries	☐	☐	Kidney disease	☐	☐	Extensive confinement by illness or injury
☐	☐	Seizures, fits, convulsions, or fainting	☐	☐	Tuberculosis	☐	☐	Suffering from any other disease
☐	☐	Any other nervous disorder	☐	☐	Gastrointestinal ulcer	☐	☐	Permanent defect from illness, disease or injury

If the answer to any of the above is yes, explain in General Comments section below.

General appearance and development: Good _____ Fair _____ Poor _____

Vision: For distance: Right 20/ _____ Left 20/ _____ ☐ Without corrective lenses ☐ With corrective lenses, if worn

Horizontal field of vision: Right _____ Left _____

Evidence of disease or injury: ☐ Right _____ ☐ Left _____

Color test _____

Hearing: Right ear _____ Left ear _____

Disease or injury _____

Audiometric test: *(If audiometer is used to test hearing)* Decibel loss at 500 Hz _____ at 1,000 Hz _____ at 2,000 Hz _____

Throat: _____

Thorax: Heart _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after exercise _____

Lungs: _____

Abdomen: Scars _____ Abnormal masses _____ Tenderness _____

Hernia: ☐ Yes ☐ No If so, where? _____ Is truss worn? _____

Gastrointestinal: Ulceration or other disease _____

Genito-Urinary: Scars _____

Reflexes: Romberg _____

Pupillary _____ Light Right _____ Left _____

Accommodation: Right _____ Left _____

Knee Jerks: Right: Normal _____ Increased _____ Absent _____

Left: Normal _____ Increased _____ Absent _____

Extremities: Upper _____ Lower _____ Spine _____

Laboratory and other special findings: Urine: Spec. Gr. _____ Alb. _____ Sugar _____

Other laboratory data (Serology, etc.) _____

Radiological data _____ Electrocardiograph _____

General Comments: _____

☐ **Check here if NOT qualified**

Medical Examiner _____ License/Cert. No. & State _____
PRINT NAME & TITLE

Address _____

Medical Examiner **X** _____ Date of Examination _____
SIGNATURE MUST APPEAR HERE